		FOR OHF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0027342

Facility Name: CANTERBURY MANOR NURSING CENTER

Address: 718 NORTH MARKET STREET (Number) WATERLOO (City) 62298 (Zip Code)

County: MONROE

Telephone Number: (618)939-3650 **Fax #** (618)939-9488

IDPA ID Number: 371119687001

Date of Initial License for Current Owners: 03/01/70

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: ROGER W. BAGLEY **Telephone Number:** (618)549-8331
JAMESTOWN MANAGEMENT CORP.

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) ROGER W. BAGLEY
(Title) CONTROLLER

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	20	Skilled (SNF)	20	7,300	1
2		Skilled Pediatric (SNF/PED)			2
3	54	Intermediate (ICF)	54	19,710	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	74	TOTALS	74	27,010	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	898		682	1,580	8
9	SNF/PED					9
10	ICF	12,360	8,559		20,919	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,258	8,559	682	22,499	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.30%

D. How many bed-hold days during this year were paid by the Department? _____ (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 03/01/70

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 20 and days of care provided 682

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/05 Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number CANTERBURY MANOR NURSING CENT # 0027342 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	121,006	6,728	5,654	133,388		133,388		133,388			1
2	Food Purchase		74,223		74,223	4,809	79,032	(288)	78,744			2
3	Housekeeping	62,877	11,633		74,510	209	74,719		74,719			3
4	Laundry	56,827	6,565		63,392		63,392		63,392			4
5	Heat and Other Utilities			79,521	79,521	600	80,121		80,121			5
6	Maintenance	27,715	10,924	37,250	75,889		75,889	(1,578)	74,311			6
7	Other (specify):*											7
8	**TOTAL General Services**	268,425	110,073	122,425	500,923	5,618	506,541	(1,866)	504,675			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	820,729	34,570	71,517	926,816	(3,897)	922,919		922,919			10
10a	Therapy			285	285		285		285			10a
11	Activities	41,918	3,188	1,100	46,206	(736)	45,470	(185)	45,285			11
12	Social Services	32,678		1,100	33,778		33,778		33,778			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	895,325	37,758	74,002	1,007,085	(4,633)	1,002,452	(185)	1,002,267			16
	C. General Administration											
17	Administrative	60,732			60,732	70,171	130,903		130,903			17
18	Directors Fees											18
19	Professional Services			204,543	204,543	(122,890)	81,653	(77,437)	4,216			19
20	Dues, Fees, Subscriptions & Promotions			6,398	6,398	261	6,659	(3,009)	3,650			20
21	Clerical & General Office Expenses	24,738	6,207	5,092	36,037	22,737	58,774	(524)	58,250			21
22	Employee Benefits & Payroll Taxes			170,887	170,887	13,317	184,204		184,204			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,377	1,377	493	1,870		1,870			24
25	Other Admin. Staff Transportation					2,031	2,031		2,031			25
26	Insurance-Prop.Liab.Malpractice			43,477	43,477	2,220	45,697		45,697			26
27	Other (specify):*											27
28	**TOTAL General Administration**	85,470	6,207	431,774	523,451	(11,660)	511,791	(80,970)	430,821			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,249,220	154,038	628,201	2,031,459	(10,675)	2,020,784	(83,021)	1,937,763			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER #0027342 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			20,610	20,610	3,483	24,093	56,967	81,060			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,889	3,889		3,889	(251)	3,638			32
33	Real Estate Taxes					881	881	21,482	22,363			33
34	Rent-Facility & Grounds			354,000	354,000	6,311	360,311	(354,000)	6,311			34
35	Rent-Equipment & Vehicles			191	191		191		191			35
36	Other (specify):*											36
37	**TOTAL Ownership**			378,690	378,690	10,675	389,365	(275,802)	113,563			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		37,210	44,175	81,385		81,385		81,385			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			40,515	40,515		40,515		40,515			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		37,210	84,690	121,900		121,900		121,900			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,249,220	191,248	1,091,581	2,532,049		2,532,049	(358,823)	2,173,226			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	35,957	30		9
10	Interest and Other Investment Income	(43,599)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(288)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(42)	21		18
19	Entertainment				19
20	Contributions	(482)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,653)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(356)	20		28
29	Other-Attach Schedule	(1,763)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (13,226)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(345,597)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (345,597)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (358,823)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS
CANTERBURY MANOR NURSING CENTER
ID# 0027342
Report Period Beginning: 01/01/2005
Ending: 12/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	ELIMINATE ACTIVITY & CONTRIBUTION	$ (185)	11	1
2	INCOME PER EXPENSE			2
3				3
4	ADJUST DEFERRED MAINT EXPENSE	(1,578)	6	4
5	PER SCHEDULE XIX			5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,763)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER **#** 0027342 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(288)	0	0	0	0	0	0	0	0	0	0	(288)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(1,578)	0	0	0	0	0	0	0	0	0	0	(1,578)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,866)	0	0	0	0	0	0	0	0	0	0	(1,866)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(185)	0	0	0	0	0	0	0	0	0	0	(185)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(185)	0	0	0	0	0	0	0	0	0	0	(185)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(77,437)	0	0	0	0	0	0	0	0	0	(77,437)	19
20	Fees, Subscriptions & Promotions	(3,009)	0	0	0	0	0	0	0	0	0	0	(3,009)	20
21	Clerical & General Office Expenses	(524)	0	0	0	0	0	0	0	0	0	0	(524)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(3,533)	(77,437)	0	0	0	0	0	0	0	0	0	(80,970)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(5,584)	(77,437)	0	0	0	0	0	0	0	0	0	(83,021)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	35,957	21,010	0	0	0	0	0	0	0	0	0	56,967	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(43,599)	43,348	0	0	0	0	0	0	0	0	0	(251)	32
33	Real Estate Taxes	0	21,482	0	0	0	0	0	0	0	0	0	21,482	33
34	Rent-Facility & Grounds	0	(354,000)	0	0	0	0	0	0	0	0	0	(354,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(7,642)	(268,160)	0	0	0	0	0	0	0	0	0	(275,802)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(13,226)	(345,597)	0	0	0	0	0	0	0	0	0	(358,823)	45

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
LIST ATTACHED		FAIR ACRES NURSING HOME	DUQUOIN	Jamestown Mgmt	Carbondale	Management
		FAIRVIEW NURSING CENTER	DUQUOIN	Corp		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	MANAGEMENT FEES	$ 200,499	JAMESTOWN MANAGEMENT CORPORATION	10.00%	$ 123,062	$ (77,437)	1
2	V	33	REAL ESTATE TAXES		WATERLOO LAND TRUST	100.00%	21,482	21,482	2
3	V	34	RENT	354,000	WATERLOO LAND TRUST	100.00%		(354,000)	3
4	V	32	INTEREST EXPENSE		WATERLOO LAND TRUST	100.00%	43,591	43,591	4
5	V	30	DEPRECIATION		WATERLOO LAND TRUST	100.00%	21,010	21,010	5
6	V	32	INTEREST INCOME		WATERLOO LAND TRUST	100.00%	(243)	(243)	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 554,499			$ 208,902	$ * (345,597)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number CANTERBURY MANOR NURSING CENT # 0027342 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	***OWNER'S COMPENSATION HAS BEEN ELIMINATED PRIOR TO THE COST REPORT.***								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Jamestown Management Corporation
Street Address: 1001 E. Main Bldg 4a
City / State / Zip Code: Carbondale, IL 62901
Phone Number: ((618) 549-8331
Fax Number: ((618) 548-0133

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	HOURS OF SERVICE	15,278		$ 5,383	$	3,652	$ 1,287	1
2	5	UTILITIES	HOURS OF SERVICE	15,278		2,509		3,652	600	2
3	17	ADMINISTRATIVE	HOURS OF SERVICE	10,400		293,555	293,555	2,486	70,171	3
4	19	LEGAL & ACCOUNTING	HOURS OF SERVICE	15,278		720		3,652	172	4
5	20	LICENSES & DUES	HOURS OF SERVICE	15,278		1,092		3,652	261	5
6	21	CLERICAL SALARIES	HOURS OF SERVICE	4,878		79,706	79,706	1,166	19,052	6
7	21	CLERICAL & GEN OFFICE EX	HOURS OF SERVICE	15,278		11,644		3,652	2,783	7
8	22	PAYROLL TAXES	HOURS OF SERVICE	15,278		55,712		3,652	13,317	8
9	24	SEMINARS	HOURS OF SERVICE	10,400		2,061		2,486	493	9
10	25	AUTO EXPENSE	HOURS OF SERVICE	10,400		8,495		2,486	2,031	10
11	26	GENERAL INSURANCE	HOURS OF SERVICE	15,278		9,287		3,652	2,220	11
12	30	DEPRECIATION	HOURS OF SERVICE	15,278		14,572		3,652	3,483	12
13	33	REAL ESTATE TAXES	HOURS OF SERVICE	15,278		3,685		3,652	881	13
14	34	RENT	HOURS OF SERVICE	15,278		26,400		3,652	6,311	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 514,821	$ 373,261		$ 123,062	25

Facility Name & ID Number CANTERBURY MANOR NURSING CENTI # 0027342 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Canterbury Manor Nursing	x		1st Mortgage	$4,741.00	7/20/00	$ 565,000	$	7/20/25	0.0900	$ 43,591	1
2	Center											2
3												3
4												4
5												5
	Working Capital											
6	1st National of Waterloo		x	Revolving line of credit				15,000		variable	3,889	6
7				for operating funds								7
8												8
9	TOTAL Facility Related				$4,741.00		$ 565,000	$ 15,000			$ 47,480	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 565,000	$ 15,000			$ 47,480	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER **#** 0027342 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	21,482	2
3. Under or (over) accrual (line 2 minus line 1).	$	21,482	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	21,482	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	18,418	8
	2001	20,341	9
	2002	20,538	10
	2003	20,780	11
	2004	21,482	12

*****Line 7 does not included the Jamestown allocation from page 8 SCHVIII of $881.**

Real estate taxes on page 4 line 33 should reconcile to line 7 $21482 + Jamestown $881 = $22363.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1600.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CANTERBURY MANOR NURSING CENTER COUNTY MONROE

FACILITY IDPH LICENSE NUMBER 0027342

CONTACT PERSON REGARDING THIS REPORT ROGER W. BAGLEY

TELEPHONE (618)549-8331 FAX #: (618)549-0133

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not b entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	07-24-250-031-000	N. Market Street part lot 1 sur 640	$ 1,770.36	$ 1,770.36
2.	07-24-250-026-000	718 N. Market Street Tax Lot 6 BA	$ 19,712.13	$ 19,712.13
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 21,482.49	$ 21,482.49

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2005

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,374 B. General Construction Type: Exterior masonry Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [ ] (a) Own the Equipment [x] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Original bldg & addition	50,000	1970-75	$ 25,823	1
2	Additional land	22,597	1995	108,977	2
3	TOTALS	72,597		$ 134,800	3

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	60		1970	1970	$ 123,000	$	30	$	$	$ 123,000	4
5	14		1976	1976	80,226		25			80,226	5
6			1970	1970	49,513		25			49,513	6
7			1976	1976	866		10			866	7
8			1976	1976	10,413		15			10,413	8
	Improvement Type**										
9	VARIOUS/FULLY DEPRECIATED			1970	14,327		various			14,327	9
10	REMODELING			1974	565		25			565	10
11	NURSES CALL SYSTEM			1976	7,457		15			7,457	11
12	NURSES STATION			1976	30,851		20			30,851	12
13	SPRINKLER & SMOKE DETECTOR			1976	34,295		25			34,295	13
14	REMODELING			1977	6,714		15-20			6,714	14
15	LAND IMPROVEMENTS			1980	900		15			900	15
16	LAND & GUTTERING			1981	7,199		15			7,199	16
17	ROOF REPAIR & ACTIVITY ROOM			1986	30,422		15			30,422	17
18	PARKING LOT			1987	1,670		7			1,670	18
19	GAS LINE			1989	1,637		15			1,637	19
20	VARIOUS IMPROVEMENTS			1990	13,962	307	15	463	156	13,962	20
21	CABINETS & FLOORING			1994	2,461	164	15	164		1,887	21
22	VARIOUS IMPROVEMENTS			1994	21,632	1,442	15	1,442		16,583	22
23	ROOF REPAIR			1995	2,565	171	15	171		1,796	23
24	WATER HEATER			1995	3,000		15	200	200	2,100	24
25	FIRE ALARM			1995	7,207		15	480	480	5,040	25
26	TELEPHONE SYSTEM			1995	713		20	36	36	378	26
27	CARPETING			1996	2,423		7			2,423	27
28	RENOVATING ROOMS			1996	4,403	440	10	440		4,180	28
29	REPLACED WATER HEATER			1996	550		15	37	37	351	29
30	REPAIR SHOWER			1996	2,244	224	10	224		2,128	30
31	LANDSCAPING			1996	973	97	10	97		922	31
32	REPLACE WATER HEATER			1996	680		15	45	45	428	32
33	Labor/materials to remove existing and install new waterproof			1996	4,009	401	10	401		3,408	33
34	wallcovering and floor tile										34
35	Labor/materials to remove and install new cabinets/countertops			1996	6,853	685	10	685		5,823	35
36	in nursing station										36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	REPAIR PLUMBING	1997	$ 4,010	$ 267	15	$ 267	$	$ 2,270	37
38	REPAIR GROUNDWATER DRAIN	1997	790	53	15	53		450	38
39	PREP AND SEAL PARKING LOT	1997	1,145		5			1,145	39
40	SIGN	1997	531		5			531	40
41	OVERBED LIGHTING	1998	8,636	864	15	576	(288)	4,320	41
42	FLOORTILE AND CARPETING	1998	10,612	758	15	707	(51)	5,303	42
43	LANDSCAPING	1998	4,817	482	10	482		3,615	43
44	Labor/materials to remove entry way, rebuild walls, paint	1998	11,907	1,191	15	794	(397)	5,955	44
45	& replace elec serv in DON, Socserv, breakroom. Move wall								45
46	expand kitchen. Created storage area by relocating doors								46
47	Trim, pictures, mirrors & other permanent fixtures to	1998	3,025	49	5		(49)	3,025	47
48	refurbish the remodeled building.								48
49	PARKING LOT	1998	56,963		15	3,798	3,798	28,485	49
50	WATER SOFTNER	1998	1,400		10	140	140	1,050	50
51	FIRE SUPPRESSION SYSTEM	198	1,356		10	136	136	1,020	51
52	GAZEBO	1999	4,084		20	204	204	1,326	52
53	COURTYARD AWNINGSS	1999	850		5			850	53
54	INSTALL 911 ALARM SYSTEM	1999	519		5			519	54
55	LANDSCAPING AND SIDEWALKS	1999	2,189	219	10	219		1,423	55
56	WINDOWS FOR FRONT OF BUILDING	1999	2,658	266	10	266		1,729	56
57	LANDSCAPING OF COURTYARD	1999	466	47	10	47		305	57
58	WALLPAPERING	1999	218		5			218	58
59	BUILDING ADDITION	1999	411,559		15	27,437	27,437	150,904	59
60	ADJUSTMENT TO 1999 DPA COST REPORT	2000	(173)						60
61	BUILDING ADDITION	2000	17,651		15	1,177	1,177	6,473	61
62	DOOR ALARM SYSTEM	2000	5,996		10	600	600	3,300	62
63	Labor/materials to install new cabinets/countertops, relocate	2000	1,346		10	135	135	742	63
64	heating, electrical services, and lighting in the breakroom								64
65	EXTENSION & MODEM JACK INSTALLED IN NEW OFFICE	2000	1,071		10	107	107	589	65
66	Labor/materials to remove existing wall and relocate wall	2000	9,093	670	10	909	239	5,000	66
67	to expand nurses station and install new cabinetry &								67
68	countertops, lighting, and electrical services								68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,036,449	$ 8,797		$ 42,939	$ 34,142	$ 692,011	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,036,449	$ 8,797		$ 42,939	$ 34,142	$ 692,011	1
2	INSTALL TILE FLOORING IN EAST WING	2000	6,858	505	15	457	(48)	2,514	2
3	CABINETS INSTALLED IN 6 MED ROOMS	2000	5,789	427	15	386	(41)	2,123	3
4	Labor and materials to remove existing cabinetry and sinks	2000	2,845	210	15	190	(20)	1,045	4
5	and install new cabinets/sinks, replace plumbing and								5
6	electrical on east wing.								6
7	ABSTRACT WATER FOUNTAIN IN COURTYARD	2000	1,155	103	5	115	12	1,155	7
8	FRUIT URN FOUNTAIN IN DRIVE	2000	945	84	5	94	10	945	8
9	LANDSCAPING	2000	1,519	112	10	152	40	836	9
10	ELEVATED EAST WING FLOOR/WALLS OF BUILDING	2001	3,875	258	15	258		1,161	10
11	Replaced employee door, new frame, door, and hardware	2001	2,129	213	10	213		958	11
12	Code modifications to fire sprinkler system	2001	2,566	257	10	257		1,156	12
13	Installation & replacement of aluminum patio door systen	2001	4,223	422	10	422		1,899	13
14	Replace pressure switch and repair lines in fire sprinkler sys	2002	5,790	579	10	579		2,027	14
15	SEAL AND STRIPE PARKING LOT	2002	3,440	688	5	688		2,408	15
16	Relocate 2 water meters to meet city codes	2002	1,700	113	15	113		396	16
17	REPLACED WATER HEATER	2003	3,539	619	10	354	(265)	885	17
18	REPLACED WATER SOFTNER	2003	1,913	335	10	191	(144)	478	18
19	INSTALLED WIRING FOR CABLE TV INSTALLATION	2003	2,898	556	10	290	(266)	725	19
20	Demolition and reconstruction of wall, relocate door, and	2003	6,155	616	10	616		1,540	20
21	install electrical service for laundry								21
22	Replace flooring in south hall bathroom	2004	2,039	208	10	204	(4)	306	22
23	Replaced fixtures and cabinets in soiled utility room. Repaired	2004	2,083	204	10	208	4	312	23
24	walls and doors and painted.								24
25	Replace roof on south wing and northwest slope	2005	32,123		10	1,606	1,606	1,606	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,130,033	$ 15,306		$ 50,332	$ 35,026	$ 716,486	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 99,912	$ 4,470	$ 9,765	$ 5,295	variable	$ 67,932	71
72	Current Year Purchases	4,169	834	268	(566)	variable	268	72
73	Fully Depreciated Assets	181,259				variable	181,259	73
74								74
75	TOTALS	$ 285,340	$ 5,304	$ 10,033	$ 4,729		$ 249,459	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	JAMESTOWN ALLOCATION			$	$ 3,483	$ 3,483	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$ 3,483	$ 3,483	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,550,173	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 24,093	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 63,848	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 39,755	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 965,945	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 191 Description: storage 171; carpet cleaner 20
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   WE ONLY HIRE TRAINED AIDES.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39/3;39/2	hrs	$	231	$ 17,300	$ 212	231	$ 17,512	1
2	Licensed Speech and Language Development Therapist	39/3	hrs		21	2,143		21	2,143	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39/3	hrs		296	23,199		296	23,199	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39/2	# of prescrpts				19,932		19,932	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	oxygen, tubefeeding, med supplies Other (specify): lab, xray, ambulance	39/2 39/3				1,533	17,066		18,599	13
14	TOTAL			$	548	$ 44,175	$ 37,210	548	$ 81,385	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER **#** 0027342 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 7,975	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	358,019		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	22,519		5
6	Prepaid Insurance	13,273		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 401,786	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	224,076		15
16	Equipment, at Historical Cost	218,702		16
17	Accumulated Depreciation (book methods)	(376,374)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Loan to Waterloo Land Trust	477,034		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 543,438	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 945,224	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 34,874	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	41,100		30
31	Accrued Taxes Payable (excluding real estate taxes)	16,500		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	401 k Liability	12,687		36
37	1st National of Waterloo	15,000		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 120,161	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 120,161	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 825,063	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 945,224	$	48

***(See instructions.)**

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 832,525	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 832,525	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(7,462)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (7,462)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 825,063	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,332,979	1
2	Discounts and Allowances for all Levels	44,142	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,377,121	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	69,960	6
7	Oxygen	16,758	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 86,718	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	521	19
20	Radiology and X-Ray	500	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,021	23
	D. Non-Operating Revenue		
24	Contributions	16,128	24
25	Interest and Other Investment Income***	43,599	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 59,727	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,524,587	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	500,923	31
32	Health Care	1,007,085	32
33	General Administration	523,451	33
	B. Capital Expense		
34	Ownership	378,690	34
	C. Ancillary Expense		
35	Special Cost Centers	81,385	35
36	Provider Participation Fee	40,515	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,532,049	40
41	**Income before Income Taxes (line 30 minus line 40)****	(7,462)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (7,462)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** no **If not, please attach a reconciliation.** **IL taxes are deducted federal tax return**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,980	2,104	$ 48,347	$ 22.98	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,250	2,303	47,124	20.46	3
4	Licensed Practical Nurses	14,133	15,315	264,214	17.25	4
5	CNAs & Orderlies	40,385	43,024	452,056	10.51	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,452	3,787	41,918	11.07	9
10	Activity Assistants					10
11	Social Service Workers	1,805	2,086	32,678	15.67	11
12	Dietician					12
13	Food Service Supervisor	1,858	2,120	31,617	14.91	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,270	10,184	89,389	8.78	15
16	Dishwashers					16
17	Maintenance Workers	2,082	2,286	27,715	12.12	17
18	Housekeepers	7,120	7,583	62,877	8.29	18
19	Laundry	6,007	6,434	56,827	8.83	19
20	Administrator	1,896	2,080	60,732	29.20	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,990	2,145	24,738	11.53	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Ward clerk	982	1,056	8,988	8.51	33
34	TOTAL (lines 1 - 33)	95,210	102,507	$ 1,249,220 *	$ 12.19	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	114	$ 5,654	1/3	35
36	Medical Director			9/3	36
37	Medical Records Consultant		712	10/3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		600	10/3	39
40	Physical Therapy Consultant	4	285	10A/3	40
41	Occupational Therapy Consultant			10A/3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant			10A/3	43
44	Activity Consultant	42	1,100	11/3	44
45	Social Service Consultant	42	1,100	12/3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	202	$ 9,451		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	L10/C3	50
51	Licensed Practical Nurses	673	20,929	L10/C3	51
52	Certified Nurse Assistants/Aides	2,466	49,076	L10/C3	52
53	TOTAL (lines 50 - 52)	3,139	$ 70,005		53

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JOHNNY LAW	ADMINISTRATOR	0	$ 60,732
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 60,732

B. Administrative - Other

Description	Amount
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
JAMESTOWN MGMT CORP	MANAGEMENT	$ 200,499
ADP	PAYROLL	288
BARNETT & LEVINE	ACCOUNTING	1,871
HEALTH FINANCIAL SYSTEMS	SOFTWARE MAINT	70
FREESTONE COMPUTING	COMPUTER	825
M.D. SERVICES	COMPUTER	990
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 204,543

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 30,455
Unemployment Compensation Insurance	12,272
FICA Taxes	95,565
Employee Health Insurance	14,899
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K EXPENSE	12,673
LIFE INSURANCE	88
AWARDS, ATTENDANCE, PARTIES, ETC.	2,592
VACCINES	58
BONUSES	2,285
JAMESTOWN ALLOCATION	13,317
TOTAL (agree to Schedule V, line 22, col.8)	$ 184,204

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 415
Advertising: Employee Recruitment	131
Health Care Worker Background Check	368
(Indicate # of checks performed 26)	
JAMESTOWN ALLOCATION	261
NAGNA (1403) SUBSCR(553)	1,956
CORP (404) INHAA (100)	504
MCAASD (15)	15
OTHER ADVERTISING	3,009
Less: Public Relations Expense	(2,653)
Non-allowable advertising	( )
Yellow page advertising	(356)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,650

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	324
Seminar Expense	1,053
JAMESTOWN ALLOCATION	493
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,870

**See instructions.

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	PAINTING	2005	$ 1,894	3	$	$	$	$ 316	$ 631	$ 631	$ 316	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 1,894		$	$	$	$ 316	$ 631	$ 631	$ 316	$	$

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER **#** 0027342 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a politica action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **6**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **N/A** Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **????**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

CANTERBURY MANOR NURSING CENTER #0023742

RECLASSIFICATION ON DPA COST REPORT
PAGES 3 & 4 COLUMN 5
########

LINE #	ACCOUNT TITLE	DEBIT	CREDIT
2	FOOD PURCHASES	4073	
10	NURSING & MEDICAL RECORDS		4073
	RECLASSIFY FOOD SUPPLEMENTS		
21	CLERICAL & GEN OFFICE EXPENSE	902	
10	NURSING & MEDICAL RECORDS		902
	RECLASSIFY OFFICE SUPPLIES		
10	NURSING & MEDICAL RECORDS	1078	
3	HOUSEKEEPING		1078
	RECLASSIFY SOAP & SHAMPOO		
2	FOOD PURCHASES	736	
11	ACTIVITIES		736
	RECLASSIFY FOOD USED IN ACTIVITIES		
VARIOUS	VARIOUS LINE ITEMS	123062	
19	PROFESSIONAL SERVICES		123062
	RECLASSIFY JAMESTOWN ALLOCATION		
	SEE SCHEDULE VIII FOR BREAKDOWN		